AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I (the undersigned) hereby authorize the St. Vincent Facility(ies) indicated below to disclose/obtain the following identified information. Please check all that apply:

☐ St. Vincent Hospital Indianapolis including:
- Peyton Manning Children's Hospital
- St Vincent Women's Hospital

Other _________________

☐ St. Vincent Carmel Hospital

☐ St. Vincent Fishers Hospital

☐ Seton Specialty Hospital

PATIENT VISIT INFORMATION **NOTE: ITEMS WITH * ARE REQUIRED FIELDS.**

***Name of Patient**	***Date of Birth**
Other Names used during treatment (if applicable)	Social Security Number
***Address**	***City, State, Zip Code**
***Dates of Treatment Requested**	***Purpose of Disclosure**

INFORMATION TO BE RELEASED (limit request to the minimum necessary)

	ER Report		Dictated Consults	Other: please specify
	Discharge Summary		Lab and Pathology Reports	
	Operative/Procedure Report		Therapy Notes	
	History and Physical Assessment		Radiology Reports	

RELEASE INFORMATION TO (IF NOT PATIENT)

Name	
Address	**City, State, Zip Code**

- I understand that the Protected Health Information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. ○ I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the address below. I understand that a revocation is not effective to the extent that St. Vincent has relied on the use of disclosure of the protected health information. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. ○ I understand that this authorization will expire in sixty (60) days unless otherwise specified here ._________________
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. ○ St. Vincent will not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure. ○ I understand that I have the right to refuse to sign this authorization.
- By signing this authorization, I acknowledge that I have read and understand this authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this authorization.

I understand that I am responsible for paying the applicable fees, if any.
I have the right to an estimate of the fees before receiving a copy of the records.

***Signature of Patient, Guardian, Parent, or Health Representative**	***Date Signed**

Relationship to patient (if other than self or your minor child we will require proof of authority to act on behalf of patient)

Please return the completed form to: St. Vincent Indianapolis Health, Attn: Health Information Management Department, 2001 West 86th Street, Indianapolis, Indiana 46260 or fax to 317-338-9559. Contact the Health Information Management Department at 317-338-2216 for questions.

☐ **ID checked**	**HIM associate**	**Date**